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ABSTRACT

An ad hoc committee of the American Group Psychotherapy Association (AGPA) was charged to investigate the use of group methods in Community mental health centers (CMHC), to assess the conceptual basis for the use of various group methods, to relate the use of group methods to group psychotherapy, and to evaluate trends in this area of mental health programming. Although group methods are being used in each of the ten defined areas of CMHC they are not a generalized modality of treatment. The farther one moves from the traditional mental health definition of patient populations and professional roles, the less group methods are used. The most important implication of this discussion for AGPA is to suggest the broadening scope of the mental health therapeutic systems. The group psychotherapy movement and AGPA grew out of a larger social and therapeutic movement. Thus to focus exclusively on group psychotherapy per the AGPA definition may unnecessarily constrict the contributions AGPA can make to both the therapeutic and community mental health fields. (Author/RSM)

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GROUP PSYCHOTHERAPY AND GROUP METHODS IN COMMUNITY MENTAL HEALTH PROGRAMS

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This report is an assessment of the use of group methods in community mental health programs in the United States at the present time. An ad hoc committee of the American Group Psychotherapy Association was charged to investigate the current use of group methods in community mental health programs, to assess the conceptual bases for the use of various group methods, to relate the use of various group methods to group psychotherapy per se, and to evaluate trends in this area of mental health programming as to possible directions of development especially relevant to group methods.

The backbone of this report is built upon a nation-wide survey on the use of group methods in community mental health centers--abbreviated hereafter as CMHC. An analysis of this survey was distributed to the committee members and consultants for review and comment based upon their own experience, observations, and evaluation of the extant literature. Our rationale for primary dependence on survey data was to assess the general tenor of actual practice and theory, for the published literature in this area is sparse and clinical experience is still largely exploratory. Our intent has not been to document competing theories and practices, for this area of clinical practice is too new to make such an assessment. Rather we have sought to assay the current state of practice with anticipated trends of development.

I. USE OF GROUP METHODS IN CMHC-----SURVEY RESULTS

A questionnaire was constructed to elicit information on the use of group methods in each of the ten functional areas of a comprehensive community mental health program, as defined by the Community Mental Health Center Act: inpatient services, outpatient services, partial hospitalization services, emergency services, community consultation and education services, diagnostic services, pre-care and after-care services, rehabilitation services, training services, research and evaluation services. In addition, information was elicited on the number of different types of mental health personnel who had training in group methods and the number using group methods; the philosophy of the community mental health program regarding group methods; and the orientation toward group methods.

Questionnaires were sent to the 52 community mental health centers currently federally funded and operational--chiefly in urban areas, to 32 community mental health program listed by NIMH as operating in rural areas, and to the 250 members of the American Association of Community Clinic and Center Psychiatrists. Out of this total of 409 enquiries over 120 replies from CMHC programs were returned. Of these 50 provided complete information for evaluation. From the 114 CMHC 50 usable replies were received. Thus the survey represents approximately 43% of identifiable CMHC with additional data from other community programs. Although the data cannot be considered definitive, it does reflect a broad sampling of a wide range of CMHC across the United States.

Respondents were asked to indicate the number of groups in operation and if they were planning to use a variety of group methods in each of the ten CMHC service areas. This provided wide latitude of response which would maximize the current utilization of group methods in CMHC. Each of the ten services will be discussed in terms of group method utilization.

Inpatient Services

Most CMHC do not make extensive use of group treatment methods on their inpatient services. Although some CMHC do not have inpatient services, it was rare that a CMHC listed the utilization of multiple inpatient group methods. Most CMHC reported only the use of one of two group methods.

The most frequently used group method is some type of activity group (46%). This is not too surprising in view of the fact that activity groups have been part of hospital treatment programs since the 1930's and have been incorporated into the general philosophy of hospital treatment programs. The remaining group methods are used by one-fourth to one-third of the CMHC. Next in frequency (34%) are small intensive psychotherapy groups conducted with a group of patients from the ward, but not involving the total ward population or staff. Again this represents a traditional approach to treatment that has been established over the past 30 years.

It is noteworthy that most significant advance in hospital inpatient treatment, namely the concepts of milieu therapy, dealing with the entire social system of the

ward service is not strongly represented in CMHC programs. More significantly, it was uncommon to find a CMHC report the systematic use of all the group methods that one would expect to find in a systematic milieu treatment program. Thus the basic group method, namely milieu meetings are the least in number (24%), while small and large discussion groups are more often used (31%). This finding tends to support our clinical observation that there is significant professional confusion about the theory and practice of milieu therapy. Thus unfocused or unstructured meetings of patients, or work programs, or activity groups are frequently subsumed under milieu therapy, leaving untouched the basic issues of the social system of the ward service.

Of course, as Maxwell Jones (1968) has noted in his perspectives on milieu treatment, the concepts of milieu treatment represent significant conceptual and practical differences from the traditional approach to inpatient psychiatric care based on authority and power.

It is interesting to note that family therapy methods (17%) and home visits (21%) receive as much or more attention than do milieu group methods. One interpretation of this trend is that these family group treatment methods are much closer to traditional concepts and methods of psychotherapy. Hence although these group methods were generally introduced only about 5 years ago they have been more readily incorporated into practice than the milieu group methods introduced 15 years ago, but which require a more basic shift in the premises of treatment and in the conduct of professional roles.

One final point can be made. In the individual questionnaires it was found that most CMHC would use one or two group methods and usually conduct only a small number of such groups. At the other extreme however, were a minority of CMHC that had articulated a system philosophy for the use of group methods. In these CMHC there was a large range of group methods employed which were often described as being used in complementary fashion to each other; and a large number of groups would also be used. In other words, if a CMHC does not have an articulated treatment philosophy in regard to groups it appears that group methods tend not to be employed in a systematic and coherent fashion and tend to be minimally used at that. Whereas, an articulated group philosophy tends to produce a large system of interrelated group methods in an inpatient program.

Outpatient Services

Here is where we see the major use of group treatment methods, with 73% reporting the use of intensive outpatient psychotherapy groups. This figure is misleading, for again treatment philosophy varies widely. Thus one CMHC reported that "we are individually oriented and use no groups", while another clinic said "ours is a ~~physco~~-psychoanalytic orientation, we have one behavior therapy group and that's it". On the other hand, some CMHC report that their program is group-oriented and if at all possible all patients are placed in group therapy---reporting ~~#~~ as many as 41 groups in center.

As with the inpatient services, those group methods which bear the closest relationship to traditional therapy concepts and professional roles are most widely reported (family therapy-59%, parents groups-49%).

Groups with a less intensive therapeutic focus, that is, more supportive or maintenance, for crisis problems, or chronic patients, are less widely used (small discussion groups-51%, after-care groups-40%). While group methods which might be seen as having low therapeutic potency, or having treatment goals not directed at distinct personal change but restoration of social function have a markedly lower use rate (large discussion groups-19%, drug groups-25%, multiple family groups-27%, diagnostic-intake groups-20%, social network groups-13%).

This data raises a question as to how far CMHC program concepts have moved from the treatment philosophy of intensive therapy directed toward major personal change. If it is possible to suggest an interpretation of these figures, it is that the major thrust of outpatient CMHC services continue to be the continuation of a preponderant emphasis on traditional goals of mental health services, with a minor use of group methods at social maintenance or social restoration of function ~~###~~ without changing personality structure.

Partial Hospitalization Services

As with the other services discussed, the most common group method used in the small discussion group (43%), with 25% reporting the use of large discussion groups and 23% community meetings. Since partial hospitalization programs tend to follow the pattern of the associated inpatient service, the relatively low rate of use of groups related to

the social system characteristics of the service is consistent with the trends noted for inpatient services.

However, it is significant that the early experiments with day hospitals and partial hospitalization laid strong emphasis on the use of community group interaction and use of group methods as a major dimension of a partial hospitalization program. (Cumming and Cumming, 1962; Edelson, 1969; Glasscote, et al 1969; Lamb, 1967) This data suggests that as partial hospitalization has become incorporated into CMHC programs the original treatment philosophies and concepts have not accompanied it. Thus the concept of partial hospitalization may have been strongly influenced by traditional inpatient treatment philosophies which has changed the treatment concept of partial hospitalization from the original goals and methods of the originators of this type of treatment program.

Emergency and Diagnostic Services

Here group methods are minimally used (diagnostic groups - 10%; crisis or brief therapy groups - 20%). It is here that mental health concpets may find the clearest expression of differences. Those who hold that extensive knowledge of the individual personality and genetic bakkground is essential to diagnosis and treatment indicated that groups were inappropriate for either diagnostic appraisal or the treatment of emergency situations.

On the other hand, there were some CMHC who suggested a very different conaept of mental health, namely that the most inportane diagnostic information had to dow with current interpersonal functioning. In the view of these professionals, the use of group diagnostic methods is the method of choice. Most frequently the diagnostic groups consisted of family or social relations of a nominated patient; while some CMHC reported the use of diagnostic groups of non-related persons. Similarly, emergency treatment according to this mental health philosophy can best be carried out in terms of dealing with interpersonal interaction patterns in either family groups or non-related groups. (Abrahams & Enright, 1965; Bloch, 1968; Dillon, 1965; Pattison, et al, 1965; Sadock, et al, 1968)

However, at the present time, most CMHC state quite explicitly the importance of

individual diagnostic and emergency services. This position seems to be determined more by a philosophy of personality and treatment, rather than from experimentation or clinical trial of group methods in this area. (Peck & Kaplan, 1966)

Community Consultation and Education Services

A majority of CMHC d/#/p#p0f/ report group methods used in community consultation (66%), with a smaller number active in community education (46%). Again there is wide variation in the degree of such activities. Thus some CMHC use group methods only in occasional consultation and education programs, while in other CMHC the use of group methods in consultation and education appears to be a very major activity involving a large number of personnel and their time, and involving many parts of the community. Consultation is the major activity, and consultation to defined agencies is most often found (66%). This is not unexpected in that this no doubt reflects liaison in regard to traditionally defined mental health problems. However as one moves away from direct clinical concerns there is a drop-off in activities. Thus consultation to community groups without clinical concerns is 41%,to social action groups is 31%, and the sponsorship of natural community groups is 36%. In terms of primary prevention concepts of community mental health one finds much less involvem ent in the community than with consultation and education related to secondard or tertiary prevention. (Altrocchi, et al, 1965; Blomberg 1958; Kevin, 1963)

Training Services

Here data was compared for professionals and non-professionals, because a major concern in community mental health programs, especially in urban areas, is for the employment and training of indigenous and other non-professionals. Further, training in mental health services is a major pathway suggested for movement of the poor unskilled into new positions of social competency and social participation. In almost every instance CMHC offer less trainngg to non-professionals than to professionals, although this may not necessarily imply either a positive or negative finding, particularly in CMHC programs where the target population consists of socially competent people, such as a suburban population. On the other hand, work and training for non-professionals might well be a major activity of a CMHC serving an urban ghetto.

Here again, those group methods most closely related to traditional therapeutic goals and roles are most frequently taught. Thus group therapy methods is the most frequent training (43%), followed by teaching of group dynamics (39%), and then observation of groups (36%). However these training group methods are not particularly unique to CMHC programs as distinct from traditional mental health services. When one examines the training offered in group methods most unique and particularly germane to CMHC philosophy and programming only about one-fourth of the CMHC offer training in these group methods: community organization-20%, group consultation-24%, group work-26%, group social action-11%. One interesting question this data suggests, is the degree to which community related mental services are being implemented in CMHC and to what degree CMHC are providing traditional mental health services in the community according to traditional models of health, illness, and intervention.

One somewhat surprising finding was the fairly large number of CMHC providing some type of personal group experience for trainees (41%). Some CMHC reported the extensive use of group sensitivity laboratories not only for staff, but as a service to the community. (Gottschalk & Pattison, 1969) In several CMHC this is a major communtiy activity of the professionals. Again this fact suggest the continuation and extension of the traditional mental health concern for personal growth and less concern for the nurturance of human social activities.

Research and Evaluation Services

In view of the relatively slow growth of group psychotherapy research in general, the fact that 24% of CMHC report some group-related research suggests that the community mental health movement may spur the growth of group research, particularly in relation to innovative group methods.

Summary of Group Methods used in the Ten CMHC Services

Of the large variety and types of groups suggested in the questionnaire sent to CMHC, all were used to some extent. Some CMHC use very few group methods or even eschew the use of any group methods. Other CMHC use group methods in a spotty and sporadic fashion, one might say even in an idiosyncratic fashion. And other CMHC have developed very explicit and articulated conepts and methods for the use of groups.

Group methods are being used in each of the ten defined services of a CMHC. The most frequent services where groups are used are in outpatient services, and then in community consultation and education services. Group methods are least used in emergency and diagnostic services.

Group methods are however not a generalized modality found in CMHC. Only traditional intensive outpatient psychotherapy groups are used by a large majority of CMHC. The farther one moves from traditional mental health definitions of patient population and mental health professional roles the less group methods are used. However, this may not reflect attitudes toward the use of groups in these less traditional manners, but merely the fact that CMHC services cluster around more traditional services and less emphasis in generally given to the non-traditional services and functions.

Use of Groups for Staff Function Services

Since there has been considerable discussion about staff patterns and relationships in CMHC we also sought data on the use of group methods for staff functioning. Although there has been much discussion in the literature on the importance of staff function on the treatment and behavior of patients a minority of CMHC use group methods to deal with staff functioning. (Artiss & Schiff, 1968; Schiff, 1969) The exception as outpatient service (66%). Only 40% of inpatient services have group staff meetings, which correlates with the low number of milieu programs reported. Most CMHC apparently do not distinguish between work-task issues and staff relationship issues. Only 13% of CMHC have group meetings for dealing solely with staff issues, although 40% report meetings which concern staff relations.

Group Orientation of CMHC Staff

Finally to assess orientation toward group methods in CMHC we obtained data on CMHC staff who had group training and those who were using group methods. Approximately half of the 1160 personnel in this CMHC survey have had some type of group training and about the same number (although not necessarily the same people) use some type of group methods in their CMHC work.

Interestingly, psychiatrists were the lowest in using group methods and psychologists were the highest. Most of the lower echelon personnel, nurses and non-professionals do not have training in group methods and do not use group methods.

Most of the CMHC reported that the mental health professionals whom they hired did not have any training in group methods. Since the use of groups was felt to be a necessary activity the CMHC then undertook to provide inservice training in group ~~training~~ methods for their staff. Thus the number of CMHC staff possessing some group training does not reflect the training providing in the mental health professional schools. The fact that a large number of CMHC do provide group training of some type supports the importance which many CMHC programs do give to group concepts and methods.

II. CONCEPTUAL APPROACHES TO THE USE OF GROUP METHODS IN CMHC.

The General Conceptual Issues

The community mental health movement has been alternately seen as a movement to solidify reactionary trends in mental health services or as a revolutionary social and political movement. Perhaps both analyses are correct, and it may be that there are explicit and implicit proponents of both positions. Those who see the community mental health movement as potentially reactionary point out that CMHC programs may be established in communities that follow the current societal definitions of health and illness and provide an extension of mental health services that maintains the same type of therapist-patient relationships that have been exemplified in the "institutionalitis" attitudes documented in many recent studies. In this view the CMHC perpetuates the current societal attitude toward mental illness and associated deviancy, perpetuates a view of human behavior that ignores the importance of social relationships, and perpetuates modes of treatment that are too expensive, of dubious merit, and continues to be relatively unaccessable to the bulk of the population who most need mental health services.

Those who see the community mental health movement as potentially revolutionary point to the expanding involvement of community mental health personnel in many areas of community life and action. Critics deplore this involvement beyond the strictly clinical concern for those defined as mentally ill, while proponents hail such involvement as a break-through which will free mental health concerns from the rigidities of traditional definitions of the mentally ill, the traditional definitions of the goals of treatment, and the traditional means of intervention. In the revolutionary view the community mental health movement is seen as merging imperceptibly into the tasks of

social maintenance, social welfare, and social action.

Although this is presented in polar extremes, most CMHC probably fall along a wide continuum, depending on the views of the staff of a CMHC and probably to a significant extent depending upon the community involved.

As already suggested in the survey results, the use of groups in CMHC programs may reflect to a significant degree the conceptual philosophy of that CMHC. For example, if a CMHC views mental illness as primarily an intrapsychic process for which personality reconstruction is the major goal of treatment, then the construction of CMHC programs will probably be structured to recruit patients who will fit this mold, or else experience "organizational strain" with the community. Further, with this orientation one would expect rather traditional group methods to be used which were synchronous with these traditional treatment goals. Such a CMHC program would probably tend to accept the current social definitions of who the patient is to be treated and would not develop programs and use group methods that involved non-patients or aimed at goals other than the treatment of personal psychopathology.

A more mediating position might conceive of mental dysfunction in a broader context and seek to develop CMHC programs involving significant others such as family and social relations. Such CMHC programs may be expected to develop programs aimed at social rehabilitation and increased life effectiveness. In such programs one might anticipate an emphasis on socialization experiences in each of the various clinical treatment services and employ a large gamut of group treatment methods. However such CMHC might well not define their role as a social agent in the larger community and might contain their efforts to those defined as mentally ill and those in close relationship to them. This would appear to be the predominant philosophy of most CMHC.

Finally, there are some CMHC programs who view their task as addressing the social processes of the community--the manner by which the mentally ill are defined, how social deviants are funnelled to various institutions of the community, the social and cultural processes that are seen as the anlage of mental deviance. Such CMHC might well question the use the community wishes to make of their services, may attempt to change community attitudes and actions, and may well seek to use group methods that are not in the strict

sense "treatment" but are aimed at addressing basic processes in the community. Here treatment takes on a larger, more diffuse and less specific definition. (Klein, 1968; Peck, Kaplan & Roman, 1966.)

Conceptual Issues of Psychotherapy

The data our survey pertaining to conceptual approaches to the use of group methods in CMHC indicates that the basic conceptual issues do not relate directly to group methods. Rather, the basic conceptual questions pertain to concepts of psychopathology and treatment issues, as well as the larger issue of the role of the whole mental health enterprise.

The CMHC movement reflects an attempt to synthesize two rather disparate social systems of mental health care. The first system is the traditional mental hospital system of care. People who developed socially disruptive behavior and were defined as mentally ill were extruded from society and sent to the mental hospital for treatment of their deviancy, with the expectation that the treatment would return the person to his pre-morbid capacity to function in his society. The treatment task of the psychiatrist was to redress the deviant behavior.

The second system was that of psychotherapy. Here the person was not necessarily involved in socially disruptive behavior, nor defined as deviant by his society. He privately sought help from a psychotherapist to alleviate primarily internal distress. Referral in the system was via word of mouth, by what Kadushin (1969) calls "the friends of psychotherapy society".

Until the CMHC movement began there was almost no overlap between these two systems of mental health care. Furthermore, the mental hospital system served the lowest 20% of the population in terms of social competence, while the psychotherapy system served the top 20%. In between, the majority of the population had no readily available system of mental health care.

It is true that an intermediary system had developed - those social work and family service agencies that provided psychotherapeutic services to the middle class and the working class (Scheidlinger, 1956). However, these services, it may appear, did not exert a major influence on mental health service philosophy, nor garner significant

bureaucratic support from the psychiatric profession or governmental funding agencies. Further, both these social agencies and psychiatric outpatient clinics attached to hospitals were generally well developed only in the largest urban areas, leaving the bulk of the population in our smaller cities and towns with little available mental health services.

A major consequence of these incongruities has been an extension of both of the previous systems, with one or the other predominating. While the concept of a new system of mental health care embracing features of both the mental hospital system and the psychotherapy system addressed to the mental health needs of a broad range of the populace has not been developed.

Those CMHC developed within the mental hospital system have stressed programs that aim at social rehabilitation, whereas CMHC within the psychotherapy system have aimed at personal change and growth.

However, both these traditional systems by and large accept a definition of professional roles that society has given them. That is, they accept who society will define as a patient, they accept society definitions of mental illness, they accept the sanctions which society places on the nominated patient, and they acdept the demands which the society makes on their treatment system. In other words, both systems of mental health care are unwitting pawns of their society.

To give examples of each instance. The CMHC in the mental hospital tradition accept patients for treatment that society has defined as deviant and allocated for treatment at the CMHC. The major distinctive between the old traditional mental hospital and the CMHC in this instance is that the CMHC conducts the same mental hospital style of treatment only located in more central community facilities.

Likewise, in the psychotherapy tradition, patients are accepted for treatment who volunteer for care and receive traditional psychotherapeutic assistance in a CMHC. The major distinctive here is that the psychotherapist is in public pay rather than private, and a larger number of persons receive psychotherapy who would not otherwise because the referral system is more formal and public.

In wither of these two traditional systems, the use of group treatment methods

will be in accord with the prevailing tradition. Thus in the mental hospital type CMHC we find groups that promote return to socialization, whereas in the psychotherapy type CHMC we find groups that provide intensive personal psychotherapy. One would not expect to find significant cross-over in the types of group methods used in each of these two CMHC systems.

However, the CMHC movement does address itself to both the goals of social rehabilitation and personal psychotherapy. Yet neither traditional system of mental health care provides an adequate conceptual model to mediate both goals. As a consequence we are witnessing the development of a new model of psychopathology and a new model of treatment intervention that we shall call the social system model. We can trace the development of this model in at least four areas of mental health care: in psychotherapy, in mental hospital treatment, in social work, and in the laboratory group movement.

In Psychotherapy:

Psychotherapy was developed within the medical tradition of the late 19th century, a very narrow medical tradition in terms of concepts of pathology. Koch's postulates regarding specific germs as the sole etiology of disease was consonant with a view of pathology as solely a property of the organism. It took nearly 50 years to develop a pathology of organism in environment as more adequate description of pathology.

Similarly, at the turn of the 20th century psychology was the study of individual minds. It was not until nearly 50 years later that social psychology was to emerge as a definitive discipline, and for such concepts to be applied to clinical theory.

Thus it is understandable that psychotherapy began as an individualistic enterprise, based on an individualistic concept of psychopathology and an individualistic concept of treatment intervention.

The first step away from an individualistic orientation came with the development of the child guidance movement in the 1920's where the parents were included in some adjunctive care, along with the "sick" child. The second step came with the development of group psychotherapy in the 1930's, which began as a treatment of <u>individual</u> sick patients <u>in</u> a group, and by the 1940's had moved toward a group process orientation of treatment of <u>all</u> persons simultaneously <u>by</u> the group. The third step was the introduction

of family therapy in the 1950's. Family therapy now included "patients" and "non-patients", and included people who were related to each other and lived with each other. The fourth step in the early 1960's was the introduction of multiple family groups and married couples groups, that mixed related and non-related persons. The fifth step in the mid-1960's was the movement of treatment, both individual and family, from the office into the home, where the therapist or teams of therapists were faced with a more permeable social system in its natural setting. The sixth and final step, occuring in the late 1960's has been the development of social-network therapy where the focus is on the social system of the nominated "patient" or family, including friends, kin, and others in a functionally related network of relationships. Thus psychotherapy has moved from the individual as a focus to the social system as the focus for both a definition of psychopathology and a definition of intervention.

In the Mental Hospital Treatment System:

Treatment within the mental hospital system demonstrates a similar progression. Modern treatment beyond custodial care, began with individual psychotherapy of patients living in the hospital. Then came the introduction of open-door policies with social activities that might be termed a therapeutic milieu. This was followed by patient psychotherapy groups and patient self-government groups. And finally the full development of milieu therapy, that is, the deliberate management of the entire social system of the hospital in which the psychotherapist does not treat a specific patient, but focuses on directing the social system so that it will operate in a therapeutic fashion. This shift has been so decisive that some would not call this psychotherapy, but rather socio-therapy.

In the Social Work System:

Early social work in the community was case-work, that is, the identification of persons in distress. Case-work was directed toward helping individual persons with their rent, child-care, food, jobs, etc. The second step was the development of local community groups to solve problems-in-common, or the nurturance of natural community groups. This was the classical group-work appraach. The third step has been in the area of social work called community organization. Here the aim is to intervene

in the entire social system of the community: to launch broad-scale social action programs aimed at changing basic social programs, social policies, and social organization of an entire community.

It should be noted that the above sequence in social work deals only with those developments perhaps most unique to the social work tradition, and not to the development in social work where the profession appropriated techniques of individual and group psychotherapy from with the psychotherapy tradition under discussion here. (Scheidlinger, 1958)

In the Educational-Organizational NTL System:

The NTL experiments in adult education began with the aim to assist people in communities to work together in a more democratic and humanistic fashion. The first attempts in the NTL laboratories centered on bringing individuals together in groups that would foster individual awareness and growth. Although the individual experiences were exciting, it was found that when the individual returned home to his community or job his newly learned behavior was quickly vitiated by the ongoing pressures of his social system. The next step was to bring people from the same community or company together for individual growth experiences at the NTL laboratory. However, when this small group returned home, even with mutual reinforcement, their large social systems quickly brought pressures to bear that subverted their newly formed behavior patterns. The final step has been to move the educational experience from the laboratory to the natural community or company setting. There intervention training is carried on in the context of the ongoing social system, with intervention aimed at the entire social system, and not just at individual members of the system.

Now the Community Mental Health Center movement was launched with a mandate to coordinate and integrate mental health services that embrace features of the psychotherapy system, the mental hospital system, the social work system, and the educational-training system, hence the use of the term "comprehensive" center.

Such integration and coordination cannot be achieved, however, without an embracing conceptual approach. The so-called "team approach" does not guarantee integration, and may more often than not only produce competition. Further, clinicians

from each of the above four systems have usually had little experience in any of the other systems save their own. And finally, most clinicians within each of these four systems has typically not moved to the social system orientation described above as the end-product of each system's development. Therefore, it is not surprising that the CMHC do not present a coherent conceptual system of operation that embraces the social system characteristics of each of the above four systems.

This discussion is intended to briefly summarize a conceptual model of CMHC as an institution that is self-consciously aware of its place in the community social system, and deliberately deploys its programs in terms of various levels of social system interaction. (Attneave, 1969; Averswald, 1968; Klein, 1968; Hoffman & Long, 1969; Peck, 1968; Speck & Rueveni, 1969.)

Conceptual Models of CMHC and the Use of Group Methods.

If we analyze the conceptual philosophy of a CMHC along the continuum from the traditional individualistic approach to the social system approach we may observe that use of different group methods will be contingent upon where the CMHC lies along the continuum.

The CMHC operated along the most individualistic lines views mental illness as primarily an intrapsychic process for which personality reconstruction is the major goal of treatment. In such CMHC we find the use of those group methods which are primarily aimed at personality resturcture. These would primarily be intensive long term outpatient groups. We do not find inpatient programs that systematically employ socio-therapy, intake groups or supportive groups, or groups that aim at primarily strengthening family and social relationships.

A more mediating position would be those CMHC that conceive of mental dysfunction in a broader context and seek to develop treatment programs that involve significant others such as family and social relations. In these CMHC we find programs aimed at social rehabilitation and increased life effectiveness. Here we find an emphasis on inpatient socio-therapy, pre-care and after-care groups, intake groups, and various types of family therapy and social network therapy groups. In such CMHC there may be a wide variety of groups that aim at social rehabilitation at various stages of the

social rehabilitation process, with perhaps less emphasis on even neglect of long term intensive group psychotherapy.

At the end of the spectrum are those CMHC that view their task as addressing the social processes of the community---the manner by the mentally ill are defined, how social deviants are funnelled to various institutions of the community, the social and cultural processes that are the anlage of deviance. Such CMHC may well employ group methods that embrace larger community groups, community groups, natural groups in the community, task groups, social action groups, and various types of groups for "normals" that will motivate and catalyze people for community action. These latter types of groups would be seen as social action groups. (Klein, 1968; Mays & Klein, 1964; Peck, 1968; Scheidlinger, 1968, 1969).

The majority of CMHC fall within the individualistic concept end of the continuum as represented in our survey. Thus it is not surprising that we find most CMHC not utilizing the broad range of gsoup methods that are available in our group methodology armamentarium. Interestingly, those CMHC that tend to lie at the end of the spectrum that involves social system intervention employ the most varied group methods that range from intensive group psychotherapy to community social action groups.

These variations in philosophy are reflected in the various reasons the CMHC list for their use or non-use of group methods in their programs. First, we shall look at the advantages reported in the use of group methods in CMHC. These can be listed in three categories: (1) pragmatic advantages, (2) individual advantages, (3) system advantages. These will be summarized with quotes in many instances.

Pragmatic Advantages

1. saves time because more people can be treated
2. it is a more effective and efficient use of staff time
3. is the method to use because of treatment demands, but not preferrable
4. you accomplish more par unit time
5. supplements individual therapy by giving a different point of view
6. is an effective intervention when there is marked social dysfunction
7. less expensive
8. easy access

Individual Advantages

1. forces a person to see problems he doesn't want to face

2. a person is confronted with his behavior and evaluation by his peers

3. helps the introverted and socially repressed

4. provides an ego boost through helping others and seeing their troubles

5. enhances individual awareness of feelings, problems, and biases

6. opportunity to explore interpersonal relations, express feelings, and practice modifications of behavior

7. is more insight-oriented than individual therapy.

System Advantages

1. with an emphasis on current functioning it provides the ability to deal with problems as they occur, and makes mental health processes a living thing for the total staff

2. group methods are basic to a treatment program which requires the maximum of clarity of communication between staff, patients, and program aims

3. emphasis on current behavior confronts one with the relationship between behavior in treatment and day to day living processes

4. it is paramount to see the patient and family in social context and involve ourselves in working with families and institutions that effect the patient's life.

5. the use of group methods allows different staff members to communicate more effectively with each other and maintain coherence and congruence.

6. group experience increases the focus of trainees and mental health professionals on seeing patients in socio-cultural environment in which they live and fosters understanding of how the individual transacts within his environment as well as how he is influenced by it.

7. understanding group process helps effect change in the CMHC function and structure

8. work with groups in crisis in the community helps to maintain and facilitate communication between the community and CMHC

9. group methods are necessary to provide an effective mechanism for remaining open to people in the community and keeping in touch with the needs of the community

10. groups are part of the function of a CMHC staff and the community, thus effective function of a CMHC is dependent on effective group process at multiple levels

11. group methods are the best methods of teaching socialization and breaking down the barriers between treatment and real life.

The length of the reasons given does not indicate the relative emphasis given to group methods by CMHC. Thus the most frequent advantages listed for group methods

were primarily pragmatic ones. Whereas the systematic advantages were most infrequently listed. Interestingly, those CMHC which listed pragmatic advantages used the fewest groups and used the least number of different groups. On the other hand, those CMHC that listed system advantages used the most groups and used the most number of different groups. This is illustrated by some figures from total patient service hourse hours——several CMHC listing pragmatic advantages offered 5% and 8% total group treatment, while one CMHC listing system advantage offered 70% of total treatment in group settings.

Turning now to the disadvantages of using group methods in CMHC we find that the seasons listed often appear to be ideological issues, since respondents rarely mentioned clinical experiences that suggested disadvantages. Again the disadvantages will be listed very much as reported:

1. shortage of qualified personnel who know how to conduct group treatment
2. selection is too hurried, leading to poorly matched members
3. groups should be at least 6 months long and need time to get set up
4. hard to form because of the crisis-orientation of the CMHC
5. transiency of patients who don't stay in treatment
6. it inhibits individuality
7. it gives the impression of mass production
8. it is impersonal
9. issues get lost in a group

It should be noted that a number of respondents stressed that although they favored group methods, they did not see group methods as a panacea, or that they were selective in the type of treatment offered. This is noteworthy in that there was a tendency in some respondents to polarize attitudes towards the use of groups. Some respondents occassionally replied that groups were an inferior, inadequate, superficial, or irrelevant mode of intervention. On the other hand some other respondents were noticeably "pro" group. Thus in the community mental health movement there is some continuation of an earlier ideological conflict of past decades which pitted individual therapy and group therapy as two opposing ideological positions. Most CMHC however do not see

an ideological conflict between if individual and group oriented modalities of intervention. There more significant difference in the community mental health movement may be between those who view group methods solely as a means of psychotherapy of identified patients and those who view group methods as a more embracing means of therapeutic intervention.

Conceptual Issues Related to Implementation of Group Methods

In regard to particular population considerations several issues were raised in this survey. An important issue has to do with the use of group methods in small towns and in rural population areas. There were a variety of responses as to the advantages and disadvantages of group methods in such settings. However, there is no doubt that in these rural settings the conduct of gwoup therapy may pose different problems than in a large urban area.

Some CMHC reported difficulties in conducting groups in rural areas for several reasons: 1. people in a group often knew each other, 2. people in a group were reluctant to deal with each other for fear of possible betrayal of confidences through chains of acquaintence, 3. small patient intake volume making it difficult to accumulate a number of people for a group, 4. transportation difficulties making difficult to maintain consistent meetings.

On the other hand a number of rural CMHC reported that anticipated difficulties in ~~developing~~ developing group methods did not materialize, or that the inherent difficulties could be successfully dealt with. Several CMHC reported their pleasant surprise to find how well group methods worked in rural areas, some even taking advantage of the fact that there were extra-group relationships that existed between members. Other rural CMHC have made a practice of purposely structuring groups that comprise people in a social network---thus approximating the experiments in social network therapy that have been deliberately devised in some urban programs.

A second population issue that has been debated is the use of groups with populations comprised of the poor, ethnic minorities, and the socio-economic disenfranchised groups. Most CMHC did not report on this concern, although several noted that group methods were a treatment of choice in such populations. Although there is considerable literature on differences in techniques and goals for psychotherapy of

the poor, etc. this has mostly dealt with individual psychotherapy. One area of inquiry that seems indicated is the variation in group methods and goals for various soci-economic class, racial and ethnic groups, and work with various types of people classed as social deviants.

Another issue that appeared is the question of staff participation in group treatment methods. Some CMHC define group methods as part of the province of all CMHC staff. Other CMHC define group methods as an elective which a professional can use or not use according to personal preference. Still other CMHC tend to assign certain types of professionals as responsible for group methods, while the rest of the professionals need not concern themselves.

Turning now to the ten major servides of a CMHC some further issues may be examined in regard to each service.

On inpatient servides there is wide variation in the approaches used. Some CMHC use group methods as an adjunct to traditional individually oriented psychotherapy for patient resident on a ward. Other CMHC use groups as a means of introducing patients to the idea of group therapy so that the patients will be receptive to outpatient follow-up group treatment. Other CMHC see hospitalization as an experience in group living. However, here there are also marked variations in conceptual position. For example, according to Maxwell Jones' model of milieu therapy the whole gamut of daily interaction is dealt with in patient-staff meetings. In contrast Marshall Edelson would make a sharp distinction between therapeutic issues and daily work-task issues. One issue raised by several observers is that many inpatient group progamms are conducted with little attention to the conceptual issues involved. For example, are small intensive therapy groups appropriate in an intensive milieu program. Or to what degree and in what way should staff and patients be dealt with as a social system. It has been observed that most mental health professionals receive little training in the types of social system group methods of treatment, and some observers suggest that much of inpatient group treatment is inappropriately managed because the staff have little training or orientation toward any other than traditional staff-patient relations

In regard to outpatient services the major conceptual issues seem to relate to

the emphasis CMHC programs will place on maintenance and supportive types of group methods or upon group methods aimed as restoration of social function and social relations. At this point in time, the conceptual balance appears to lie in the use of group methods aimed at personality reconstruction and much less emphasis on limited goals, maintenance and restoration goals. Implicit here of course is the question of mental health priorities in a community, the use of professional time, and the appropriateness of services to the needs of a community. It may well be that there will be significant variation in goals and priorities in various communities, and that group methods would vary accordingly. Thus a CMHC serving an affluent stable suburb might well differ markedly in the demands made upon in from a CMHC serving a ghetto community. However, the differences in philosophy and methods of a CMHC program in relation to the community served is not frequently spelled out.

In regard to partial hospitalization services the issues are much the same as with inpatient services, and has been noted previously.

In regard to diagnostic services and emergency services this is an area with both a paucity of literature and a paucity of reported experiences. Several CMHC reported interest in further exploring the use of groups for these services. In our contacts, we have observed that these uses of groups are generally much less known in CMHC programs. In a number of instances CMHC programs have begun to use groups for diagnostic and emergency services when apprised of how groups might be used in this area.

In regard to community consultation and education services, this is an area where the majority of CMHC reported a major investment of group related services. It is somewhat a contrast that most CMHC report a high per cent of their consultation and education activities are group oriented, whereas most of the literature on community consultation has been written describing individual dynamics of consultation. Group consultation is often suggested in the literature, but with few descriptions of techniques goals, problems, etc. It is striking that although CMHC report a high level of group consultation and education, they report a very low level of training in this area. This is consistent with some academic training programs in community consultation which have informed us that they focus on the methods of individual consultation but provide no training in group consultation, even though the latter may be the bulk of such CMHC

activity.

In regard to the use of groups in staff function relations there are several issues that have been raised. One crucial issue is the difference between training group experiences and therapeutic group experiences. A number of CMHC report difficulties that have arisen because of confusion between training and therapy both for their own staff and in work in the community. This is compounded by the fact that there is a current rapid proliferation of various group experience methods which has resulted in a number of CMHC reporting experiments with a variety of group experiences without any consistent focus or contract---rather a pig-in-a-poke problem. Several observers have suggested that more attention needs to be given to clearly defining and providing group training experiences for CMHC staff as well as structuring group methods for maximizing staff work functions, but clearly differentiating between them.

The same problem obtains in regard to work in the community. Many CMHC and our observers have commented that a common problem encountered in the transliteration of group treatment methods into work with other types of groups in the community. It has been noted that mental health professionals rarely have systematic training in anything other than intensive small psychotherapy groups. However such methods appear inappropriate in the conduct of many other types of group methods used in CMHC programs. There appears to be a lack of any coherent conceptual system widely known which will provide CMHC staff with a framework for using a variety of group techniques for a variety of purposes. That is, the training of CMHC personnel in a broad array of group methods, so that they are in a position to make selective use of group methods according to the needs of a variety of groups.

The Social System Model of Intervention and Group Psychotherapy

With the development of the social system model approach to therapeutic intervention in mind, we can now return to examine the use of a variety of group methods in CMHC as they relate to group psychotherapy, per se.

I would like to suggest that in terms of social system concepts, group psychotherapy as defined by the ACPA commission, represents one position of intervention (or

a close cluster of positions) along a spectrum of interventions. In this perspective then, a variety of group methods, group goals, group members, and group leaders may be employed in the social system that we term a community mental health program. How close or distant a particular group intervention is to the definition of group psychotherapy becomes irrelevant. Rather, the issues turn to those of appropriate selection of group members, techniques, goals, and leaders, according to the point in the social system one plans to intervene and to what purpose.

Several examples may illustrate the above general principle. Along the therapeutic spectrum, a diagnostic group may be used in the initial assessment of a presenting patient; later the patient may be placed in an activity group on a ward; later placed in an intensive ~~p~~ outpatient psychotherapy group, and eventually participate in a self-help group in the community.

Along the education spectrum, one may employ group dynamic principles in leading educational meetings in the community, different methods in helping organize a community action group, other group principles in conducting consultation with a group of care-agents in the community.

Along the administrative spectrum, one may use group dynamics in therapeutic administrative work such as conducting a therapeutic community, or deal with the dynamics of a professional work team, or ~~g~~/ utilized group methods to investigate and conduct consultation with a community organization.

The unitary theme that runs throughout this analysis is that each individual is part of an ever-enlarging series of social systems. Intervention will be made in terms of the goals (therapeutic, educative, work-task) and in terms of optimal point of intervention (the individual alone, or with one of the levels of social system).

Group psychotherapy, in AGPA definition terms, is an intervention made in terms of a specific goal (therapy), at a specific level of intervention (individual), using a method involving a specific social system (small group). Other group methods in a community mental health program will vary closely or widely on each of these dimensions from group psychotherapy.

III. IMPLICATION FOR CURRENT TRENDS AND FUTURE ISSUES IN THE AGPA'S DEVELOPMENT

The results of this survey suggest that attention be given to the following areas:

1. There is a need for a systematic theory relating to the use of groups in CMHC.

2. There is a need for a systematic conceptual scheme that will provide a framework for the utilization of different types of groups approaches.

3. Most mental health professionals lack training in any other than intensive group psychotherapy. There is a need for broader theoretical and technical training in a gamut of group skills.

4. Most mental health professionals do not receive adequate training in group skills in their professional schools. There is need for such training.

5. There is a need for clarification of what types of mental health personnel are needed to practice particular group methods.

6. There is a need to explore how the use of group methods and techniques may be related to the population characteristics of a community.

7. There is a need to define what types of group growth and maintenance experiences should be provided for the staff of CMHC in terms of fostering professional maturity and competence, as well as, capacity for effective group leadership.

8. There is a need to give more consideration to group consultation and education skills.

9. There is a need to develop clinical experiments with diagnostic and emergency groups.

10. There is a need to explore how the use of group methods may be used as a means a maximizing CMHC staff function apart from personal and interpersonal issues, i.e. the development of work-task staff groups.

The most important implication of this data and discussion may have for AGPA is to suggest the broadening scope of the mental health therapeutic systems. The group psychotherapy movement, and AGPA, grew out of a larger social and therapeutic movement. (Pattison, 1969) To focus exclusively on group psychotherapy, per the AGPA definition, may unnecessarily constrict the contributions, both theoretically and therapeutically, which AGPA can make to the therapeutic field, and most particularly to the community mental health field.

To approach the issue in reverse. A major function of AGPA may be to more clearly define where group psychotherapy should be positioned in a spectrum of group intervention methods, and further, help to more clearly define how, when, where, and why other group intervention may be appropriately used.

The second implication is the demonstrated need for a broadened scope of training.

Training in group psychotherapy per se does not necessarily, and probably will not, adequately equip the practitioner to analyze social systems and be able to select and use appropriately a broad array of group interventive techniques. The highly skilled group expert of practitioner may not use all group methods himself, however he should be in a position to teach, supervise, and administrate a wide variety of group interventions in a community mental health program.

The third implication is the need for skilled clinicians who can assume positions of responsibility for programming, teaching, and supervision, of group intervention methods in community mental health programs. Despite the relatviely widespread acceptance and use of group psychotherapy, the broader concepts of group intervention have yet to make a significant impact on community mental health programming, the very place where such concepts assume the highest theoretical and practical priority.

The fourth implication is the need for professional leadership, to establish training guidelines, conceptual guidelines, andpractice a/ implementation guidelines. The group psychotherapy movement has provided much of the groundwork for the development of community mental health concepts. It would appear that it would be logical and consistent for the AGPA to continue to exert creative growing leadership throughout the whole area of group intervention techniques, realizing that at the care lies the foundations of group psychotherapy upon which extension of group methods can be built.

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